Guidance to Senior Member of a Mishap Investigation Board

Mission

- To conduct a thorough safety investigation to determine the causal factors and the contributing factors IOT formulate recommendations for corrective measures that will prevent this mishap from re-occurring.

- Identify causes
  - Direct: Events/conditions that caused the mishap
  - Contributing: Events/conditions that collectively increased the likelihood of the mishap
  - Root: Events/Conditions that is corrected or eliminated would prevent recurrence

- Identify preventive measures
- Be familiar with OPNAVINST 5102.1D/MCO 5102.1B
  - Especially Chapter 6 (SIB Requirements) and Chapter 7 (Safety Privilege)

Admin

- The Safety Investigation Report (SIREP) is due 30 calendar days from date of mishap or 30 days from the date the SIB was established. The Controlling Command (MARFOR/Echelon 2 Command) will specify in the convening message.

- Protection of Privileged Information:
  - "Military and Federal courts grant protection under executive privilege to the analysis, conclusions and recommendations of command safety investigators, members of Safety Investigation Boards (SIB), and Safety Investigations Report (SIREP) endorsers. Additionally, information given by witnesses under promise of confidentiality to safety investigation boards is privileged".

- Privileged information includes, but is no to limited to…
  - Notes, photos, witness statements, SIREPS/SIREP Endorsements, drawings, or videos that a safety investigator stages or annotates.
  - SIB opinions / notes / photos with notes & analysis
  - Information used to develop conclusions / recommendations

- Privileged safety information can't be used as evidence in any other investigation, but we may use info from other investigations (JAG, NCIS).

- All SIB evidence will return to HQMC (SD) with NSC Advisor

- One evidence binder will be created and sent to the Naval Safety Center

Mishap Classification

Class A

- The resulting total cost of damages to DoD or non-DoD property in an amount of $2 million or more.
- An injury and/or occupational illness resulting in a fatality or permanent total disability.
  - Permanent total disability is the loss of both hands, eyes, feet, or when deemed so by a competent medical authority

Class B

- The resulting total cost of damages to DoD or non-DoD property is $500,000 or more, but less than $2 million.
- An injury and / or occupational illness resulting in permanent partial disability or when three or more personnel are hospitalized for inpatient care (beyond observation) as a result of a single mishap.

Class C

- The resulting total cost of damages to DoD or non-DoD property is $50,000 or more, but less than $500,000.
- A nonfatal injury that causes any loss of time from work beyond the day or shift on which it occurred.
- A nonfatal occupational illness that causes loss of time from work or disability at any time.

Investigation Priorities of Work

- Convening message (due from MARFOR)
- Endorsing chain establishment
  - Endorsing chain modification may be necessary
- SIB Appointment Letters
  - will likely be needed prior to gaining access to medical or PMO information
- Determine relevant witnesses
- After SIB is stood up a schedule should be developed
  - Visit mishap site
  - Interview witnesses
  - Collect evidence
  - Begin deliberations and determine causes of mishap
  - Begin drafting safety investigation report (SIREP)
- Enter mishap into WESS database (Mishap Command responsibility)

Analyze Facts:

- Acts level: Start at the lowest level and ask “what did the person do or not do to cause the mishap” (e.g. driving too fast, short shooter, violated an order)?

- Preconditions: Next ask “why did the person do this unsafe act”? Perhaps he or she was fatigued, going through a divorce, complacent or was trying to conduct a procedure in bad weather.

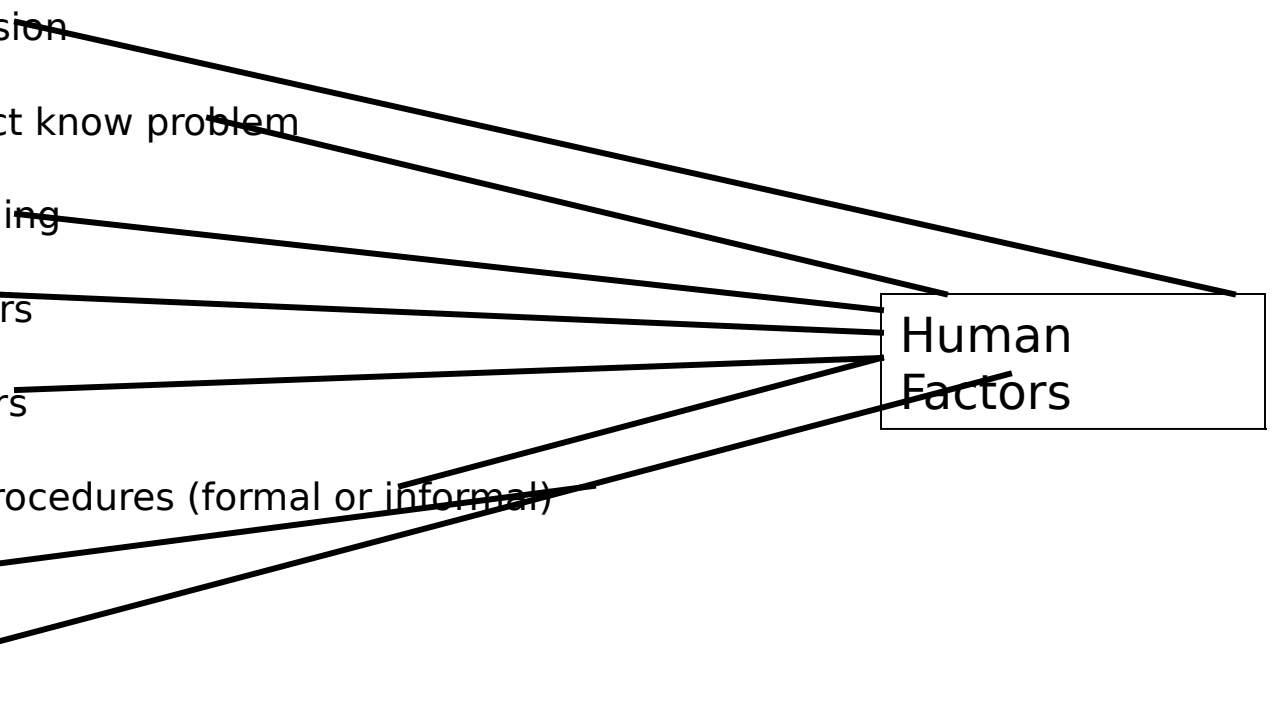
- Command: Then look at the command’s role in the mishap. Many times we find that someone in the command knew about the person’s preconditions, but didn’t take steps to prevent the mishap. Additionally, the lack of SOPs, SOPs that are unclear, or not enforced can be a factor in mishaps.

- Organization: Take a look at the organization as a whole. Perhaps the procedures given to units were unclear or the training was inadequate. Funding can be an issue to. If there is a TECOM, SYSCOM, LOGCOM deficiency then don’t hesitate to state this.

Follow the Evidence

Typical Causes of mishap:

- Lack of supervision
- Failure to correct know problem
- Minor rule bending
- Skill-based Errors
- Perception Errors
- Not following procedures (formal or informal)
- Fatigue
- Distraction
- Procedures /publications inadequate
- PPE
- Engineering



Interviewing Witnesses

Who to interview

- ***Direct Participants:*** Those physically involved in the event_
- ***Eyewitnesses:*** Those who actually observed the event
- ***Indirect Participants:*** Chain of command (Plt, Company, Staff Section)

How to conduct interviews:

- Safety interviews are not an interrogation so an informal setting will generate the most cooperation from interviewees
  - Put the witnesses at ease. Explain the purpose of the interview is only for safety
  - Marines love to talk about themselves, so begin by asking them some background questions
- Interview witnesses separately so their ideas and opinions are not influenced by others; it's easier to identify discrepancies among witnesses when they interviewed alone.
- Advice to Witness Forms: Everyone interviewed must fill one out
  - One form provides confidentiality… Must be granted by Senior Board Member
  - The other form does not provide confidentiality, but still make the statement provided"safety privileged" information
- 72 Hour Profile (direct participants only)

Interviewing continued

What <u>NOT</u> to do

- Interrupt the witness… Be an active listener and let them tell the story in their own words
- Badger or harass witnesses / interviewees
  - We want witnesses to be as relaxed as possible.
  - This is a safety investigation and we are not looking to blame anyone or hold anyone accountable in the same way that a JAGMAN would.
- Ask leading questions
  - Ask open-ended questions; “Tell me the events that took place from your perspective.”
  - Leading questions suggest the answer or contain information the investigator is looking for
    - Bad: So you went to the motor pool at 1230, didn’t you?
    - Good: Where were you at 1230?

Analyze Facts

Analysis begins following the completion of

- Mishap site documentation
- Initial interviews completion
- Evidence collection

- Analyze
  - Facts relating to the mishap
  - Conditions leading to the mishap
- Identify causal factors that allowed mishap to occur (what produced unwanted result)
  - ***Direct Cause:*** Immediate cause that is the symptom of a larger problem
  - ***Contributing Cause:*** Weather & life stressors for example (will not always have these)
  - ***Root Cause:*** Underlying cause, that if corrected would have prevented the mishap

Recommending Corrective Actions

Once causal factors have been determined it is time to develop recommendations

- *Each recommendation must have a causal factor*
  - *The endorsing chain will tear up a recommendation that is not linked to an issue identified in the SIREP*
- *Make uninhibited recommendations*
  - do not suppress valid recommendations because of expense, difficulty or unpopularity
- *Make practical recommendations*:
  - Avoid vague or wishful thinking… "All personnel shall be trained", "All drivers should", etc…
- *Make comprehensive recommendations*
  - When a hazard is common to an entire community then provide the recommendation at the appropriate level
- *A single causal factor may call for more than one recommendation*
  - *Address only one subject in each recommendation*
- Avoid dual recommendations: "do this and do that."
- *Avoid alternative recommendations:* "do this or do that."
- *Recommend final solutions instead of interim steps toward a desired end:*
  - Don't recommend half-measures like study, evaluate, research, explore, etc…

SIREP Explanation

- SIREP File Number (Assigned by MARFOR)
- Endorsing Chain (Assigned by MARFOR)

1. HHQ Chain of Command

2. HQMC: PM Ammo, SYSCOM, I&L (as required)

3. CMC Washington, D.C. SD

4. COMNAVSAFECEN Norfolk, VA (Carbon Copy)

POC & Website Info:

- **Office:** (757) 444-3520 x 7161/7198/7147
- **DSN:** 564
- **E-mail:** **Safe_Code44@navy.mil**
- **Naval Safety Center:**

http://www.public.navy.mil/navsafecen/Pages/ashore/TacOps/TacOps_Home.aspx

- **USMC Safety Division:**

http://www.marines.mil/unit/safety/Pages/welcome.aspx

Questions?